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Abstract

A response is given to the claim by Claxton and Culyer that the policies of the National Institute for Health and Clinical Excellence do not evaluate patients rather than treatments. The argument is made that the use of values such as quality of life and life-years is ethically dubious when used to choose which patients ought to receive treatments in the NHS.

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Recent articles from Rawlins and Dillon[1] and Claxton and Culyer[2] have left me somewhat disturbed by what appears to be the received wisdom at NICE regarding healthcare in general and QALYs (quality adjusted life years) in particular. I wish to respond to a specific claim which grabbed my attention in the article by Claxton and Culyer. The assertion that they make is that the policy that NICE adopts evaluates the worth of treatments and not of patients.

Claxton and Culyer's article is a response to a previous editorial by Harris in which he maintains that "NICE should not be in the business of evaluating patients rather than treatments".[3] The authors object to this assessment particularly because Harris condemns this type of evaluation as "contrary to basic morality and contrary to human rights".[3] They concede that there is indeed a difference between evaluating 'treatments' or 'procedures' and evaluating 'patients', but deny that NICE's policies amount to doing the latter. They allege that the kind of cost-effectiveness appraisals that take place "compare(s) the worth of alternative procedures . . . but this is not the same as evaluating the *worth* of patients" [My Emphasis].[2] Indeed they agree with Harris that to do so would be morally wrong. Why is it then that they cannot see that this is exactly what is happening?

At the risk of simply reiterating points that have already been made I must turn to NICE's endorsement of the QALY to explain why I think they are indeed "in the business of evaluating patients rather than treatments".[3] In the series of articles and editorials that have been published on the subject all parties seem to concur that there are two applications of the QALY. The first of these is to decide between two alternative treatments for the same person. Here there is no dispute we are truly evaluating 'treatments'. We are simply trying to select the best possible treatment for the individual patient. The second application, however, is the one causing the current discord amongst the authors. Here the QALY is used, not to choose the best treatment for a particular patient, but to either choose between the *same* treatments for *different* patients or between *different* treatments for *different* patients. This is

[*] I would like to thank the two reviewers for their helpful comments.

contentious because one camp alleges that applying the QALY in this manner is to make value judgements about people's lives, while those at NICE maintain that no value judgements are made. Unfortunately values are the basis of the QALY. This is because the standards it uses measure the worthiness of patients for treatment in respect of qualities that they possess: *quality of life* and *life-years*. For that reason any health instrument which employs these values in decisions about resource allocation is making the type of value judgements we would normally wish to avoid. If I need to decide whether to give a treatment to either patient *A* or patient *B* and I utilise the QALY then I am effectively balancing the improvement (or deterioration) in the quality of *A*'s life multiplied by the number of life-years he gains (or loses) against the same calculation for *B.* The best score will determine which person will be the most cost-effective to treat from my limited resources. Unfortunately what we are doing when we engage in this type of calculation in particular is making value judgements about the lives of those two patients (identifiable or not), because the result is that their lives and health are given lower priority. More generally we are making value judgements about the kind of people who have worthwhile lives or, indeed, about which types of lives the NHS should attempt to save or ameliorate. Now it may be that the people at NICE think that this is morally acceptable since the authors clearly state that "NICE's use of QALYs embodies representative value judgements of the UK population"[2], but the complicity of the masses does not necessarily make it so. It is in fact far from clear that NICE has even achieved such complicity. Research conducted by Erik Nord in Norway suggests that the public views patients as individually valuable and equally entitled to treatment regardless of the health outcome (p.41).[4]

In a healthcare system, that purports to evaluate and treat each patient in a fair and equal manner, it is not acceptable that you, I, NICE, or anybody else for that matter, make policy-affecting value judgements about the lives of other people because when it comes to determining the value of people's lives our opinions simply do not matter. This may be construed, as were Harris' comments, as "a denial of the allocation problem in healthcare" (p.373)[2], but that is not my purpose. If we are to say that life is valuable (and on this I think we can all agree) then we need to ask why a person's life is valuable. The answer, which has been re-stated many times by Harris himself, is not that you, I, NICE, or anybody else values that person's life, but that that person values their own life.[5] Persons and patients do not have to justify the value that they place on their own lives it is simply enough that they do value them and wish to go on living. Consequently they should not have to justify their need for medical treatment in terms of expected improvement in the quality of their lives or an increase in their life-years. Where people value their lives they ought to be treated with equal "concern and respect"[6] regarding this. Consequently they have the "right to equal concern and respect in the political decision about how these goods and opportunities are to be distributed".[6]

When we use QALYS to choose between people we take away the patients' rights to make the value judgements about their lives for themselves.

While Claxton and Culyer maintain that the use of this method of resource allocation is not evaluating the 'worth' of patients it seems patently obvious to me that it does. When we engage in the sort of evaluations inherent in QALYs we make value judgements about the kind of people that we think are worth the expenditure of public resources. Specifically we are saying that we think those people who belong to particular category have more worthwhile lives. By using the QALY we are implicitly (or perhaps explicitly) accept that those patients with a better quality of life and who live longer have more worthwhile lives. While it may be acceptable to hold a private opinion regarding this we ought not permit these personal conclusions to creep into public policy.

In a world where there are limited resources and competing healthcare interests many have argued that there is no alternative to the QALY but, of course, there are alternatives albeit unpopular ones. The two that spring easily to mind would be either a first-come first-served or a random lottery system where all citizens would have equal opportunity of *access* to the system. Both of these types of approaches to healthcare could be seen to fulfil the important criteria of justice and fairness where we do not want our conception of justice to involve selection criteria that embody value judgements about people. Nord's study, mentioned above, also suggests that people might prefer a first-come, first-served system to a QALY-based one (p.38).[4] However, those who believe that resources should be allocated on the basis of priority, need, or one's just desert would not sign up such schemes. In addition one might argue that these kinds of systems do not value all lives equally by virtue of the fact that some would be treated and others would not. Therefore, a better option might be to redirect all healthcare moneys into public health and preventative medicine. This would ensure an equality of opportunity regarding healthcare for all people thus valuing all lives equally, while at the same time still respecting the need for justice and fairness. Focusing on public health and prevention is may eventually improve the general level of health in the population, and prevent a significant amount of illness. If this is true then increasing the level of health at a population level would then have the effect of decreasing national expenditure on health care services giving us the scope for the wider use of our limited resources. Specific examples of the successful implementation of public health measures which has had the above effects are our national immunisation programmes. In particular the one against Haemophilus influenza B in children has almost eliminated the deaths and the co-morbidities from the associated meningitis.[7,8] This reduces not only immediate healthcare costs associated with treating the illness, but also ensures that a significant number of children, who might not otherwise have done so, grow up to contribute to society and the economy.

Conclusion

As we have seen the QALY can be, and in fact is, used to choose between patients and it is the continuing use of and endorsement of this particular aspect of the QALY which means that not only is the QALY morally contentious but so is any wider policy into which it is incorporated. The QALY by its very nature incorporates certain values (quality of life and life-years) and when these values are the basis of choosing between patients competing for healthcare resources then it can be said to make implicit value judgements on the lives of these patients. Therefore, it is simply a fiction to say that the QALY do not evaluate the worth of patients because this is exactly what it does and by adopting them as the standard this is also what NICE is doing. We cannot deny the resource allocation problem in healthcare but we also cannot deny the ethical problems inherent in resource allocation. Only an acceptance of these difficulties from all parties will lead us to a more ethical and equitable solution than the one currently in operation.

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